

**MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA**

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE

**PATIENT LEARNING ASSESSMENT**

OTSG APPROVED (Date)

**PART I - PATIENT'S/GUARDIAN'S SELF-ASSESSMENT**

## 1. Learning barriers

a. Do any of the following interfere with your ability to learn? Chronic illness or pain. ☐ Yes ☐ No Vision or hearing impairment. ☐ Yes ☐ No  
Reading or speaking problems. ☐ Yes ☐ No Trouble understanding or remembering. ☐ Yes ☐ Nob. What is your first language? \_\_\_\_\_ c. Do you have difficulty reading English? ☐ Yes ☐ No

## 2. Self care

a. Do you have any problems taking care of yourself? ☐ Yes ☐ No If so, please describe: \_\_\_\_\_b. Do you use alternative medicines or remedies to improve your health? ☐ Yes ☐ No If so, what? \_\_\_\_\_

3. Your preference of teaching methods (Please rank each of the following in the order of your preference, with 1 being your favorite and 3 being your least favorite method of receiving instruction from a provider. Do not use the same number twice.)

[ ] Provider expaining to me [ ] Showing me a video [ ] Giving me materials to read

## 4. Social barriers

a. Do you have, or have you ever had, religious beliefs that may impact your health care? ☐ Yes ☐ Nob. Do you have, or have you ever had, cultural beliefs surrounding health care? ☐ Yes ☐ No5. Have you ever had a bad experience with health care? ☐ Yes ☐ No6. Have you ever had a feeling of helplessness or being fearful of health care? ☐ Yes ☐ No7. Is there any reason you do not want the medical staff to teach you about your condition? ☐ Yes ☐ No If so, please explain your reason:8. Is there anyone you would like to have with you during the teaching about your condition? ☐ Yes ☐ No If so, who?9. Do you have any financial concerns about your health care? ☐ Yes ☐ No**PART II - PROVIDER'S/NURSING STAFF COMMENTS**

10. Comments on "Yes" responses to the patient's/guardian's self assessment in part I (If additional space is needed, use back of form.)

**PART III - PERIODIC VERIFICATION OF 'NO CHANGE' IN THE INFORMATION ENTERED ABOVE IN PART I**

Date	Patient's/Guardian's signature	Date	Patient's/Guardian's signature	Date	Patient's/Guardian's signature

(Continue on reverse)

PREPARED BY (Signature &amp; Title)

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

- ☐ HISTORY/PHYSICAL ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT